# Early Intervention Program Confidential Application

The Early Intervention Program (EIP) helps eligible persons with HIV who live in Washington get health care. EIP is a program of the Washington State Department of Health. We help by paying for:

- **Prescription medications on our formulary.** If you have insurance, we can pay some co-pays.
- **Limited HIV medical visits and tests.** If you have insurance, we can pay some deductibles and cover you during a pre-exist period. You must go to a provider contracted with us.
- **Insurance premiums in certain situations.**
- **Spenddown to get Medicaid coverage** (up to a certain level)**.**
- **Medicare Prescription Drug Plan and Medicare Advantage premiums; co-pays for medications on our formulary and some deductibles.**

## Do you have to pay anything for these services?

You may have to pay a fee for some services. We will let you know if you must pay.

## How do you apply?

- Complete this application.
- Collect all required documents.
- Mail the application and documents to the EIP address on the application. We do not accept faxed applications.

## How will we process your application?

- If your application is **complete**, we will send you an eligibility letter. Your eligibility will begin on the first day of the month your application is postmarked. Usually eligibility is for one year. If you are not eligible, we will tell you why.
- If your application is **not complete**, we will send you a letter telling you what we need. An incomplete application will delay your eligibility review.
- You may have to apply for Medicaid. If so, we will give you temporary eligibility and send you a Medicaid application.

## A note about confidentiality

We may talk with your case manager or health care provider about your eligibility. We can not talk to anyone else (family, friend) unless you give us a signed statement listing whom we may talk to.

## How can you contact us?

Please call us if you have any questions. Our phone number is 1-877-376-9316 statewide and (360) 236-3426 in Thurston County.

You may get more information about our program and download this application at our website: www.doh.wa.gov/cfh/hiv.htm.

This page is provided to assist you in completing this application and is yours to keep.

Early Intervention Program mailing address is:
Post Office Box 47841
Olympia, WA 98504-7841

12/2005

Client ID number

# Early Intervention Program Confidential Application

How did you first hear about our program? ☐ Case manager ☐ Health care provider ☐ Friend ☐ Other_____

**NOTE: Use a pen to complete this application.**

## Section 1: Applicant Information

| Last name | First name | | | M.I. |
|---|---|---|---|---|
| Street address (**attach proof***) | City | County | State | Zip code |
| Mailing address (if different) | City | County | State | Zip code |

***You must live in Washington to be eligible for our services. Send a copy of one of these documents to verify your **CURRENT street address**: utility bill; receipt for rent, mortgage, or lease; voter's registration card; Washington State driver's license or identification card. If you do not have a residence, talk to your case manager or call us.

| Phone number where we can reach you<br>( )<br>May we leave a voice message at this number?<br>☐Yes ☐No | Birth date | Please check the box that you feel best describes you:<br>☐ Female ☐ Male<br>☐ Transgender ☐Other |
|---|---|---|
| Case manager's name** | Case manager's phone number and agency | |

**If you do not have a case manager and would like information on case management, call us.

## Section 2: Voluntary Information

**We will not use this information to determine eligibility.**

| Social Security Number | Are you Hispanic or Latino? ☐Yes ☐No |
|---|---|

Check all of the following that apply to you:

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian/other Pacific Islander ☐ White ☐ Other: _____

Would you like to receive future renewal applications in Spanish? ☐Yes (sí) ☐No
¿Quiere recibir información en español en el futuro?

## Section 3: Resources

**Do you have any of the following resources? ☐Yes ☐No**

**If yes, enter the value.**

| Resource | What is the value? |
|---|---|
| Cash, savings account, checking account | $ |
| Real estate (not counting the home where you live) | $ |
| Trust fund | $ |
| Stocks and bonds | $ |
| Annuities | $ |
| Vehicles and recreational vehicles (not counting one automobile) | $ |
| Other (explain) | $ |

## Section 4: Income **Do you have income? ☐ Yes ☐ No Complete one section below.**

If **YES**, complete this section.

| Income Source | List the amount of your monthly GROSS income before deductions. | Include a copy of the document listed below for your most recent pay period. It must show name, pay period and gross income. |
|---|---|---|
| 1. Wages, salary, commissions, tips | $ | Check stub |
| 2. Unemployment compensation | $ | Unemployment stub. |
| 3. Social security retirement, survivor, disability or supplemental security income **(circle type received)** | $ | Benefits statement or bank statement showing direct deposit. |
| 4. Other disability income | $ | |
| 5. Veteran's benefits | $ | |
| 6. Retirement, pensions, annuities | $ | Check stub or bank statement showing direct deposit. |
| 7. Self employment | $ | Check stub, business records, or something that shows how much you earn. |
| 8. Other (explain) | $ | Something that shows how much you receive. |

If **NO**, complete this section.

Please tell us how you support yourself: (i.e., Housing, Food, Clothes, etc.)

_____

_____

_____

I understand that if I give false information about my income, I may lose benefits and/or have to pay back for services I received.

**x**_____ _____

**Signature of applicant** **Date**

## Section 5: Health Care Information. **Check Yes or No if you have any of the following:**

| | | |
|---|---|---|
| 1. DSHS Medicaid | ☐ Yes ☐ No | If Yes, do you have a spenddown? ☐ Yes ☐ No |
| 2. Medicare | ☐ Yes ☐ No<br><br>If **Yes**, you must include a copy of your Medicare card and answer the questions to the right →: | Do you have creditable health insurance (*as good as or better than* the new standard Medicare Part D)?<br><br>☐ Yes If Yes, please include a copy of your statement of creditable coverage<br><br>☐ No If No, have you enrolled in a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage with Prescription Drug Coverage (MA-PD)?<br>☐ Yes ☐ No<br>If **Yes**, Please include a copy of your PDP or MA-PD card.<br><br>Have you applied for "Extra Help" from the Social Security Administration (SSA) for Low Income Subsidy Assistance?<br>☐ Yes ☐ No<br>If **Yes**, Please include a copy of the response you received from SSA. |

## Continued From Previous Page
## Section 5: Health Care Information. Check Yes or No if you have any of the following:

| | | |
|---|---|---|
| 3. Health Insurance | ☐ Yes ☐ No | If **Yes**, include a copy (both sides) of your health insurance card and answer the following questions:<br><br>What is the name of your insurance company?<br>_____<br><br>Are you in a pre-exist period? ☐ Yes ☐ No<br>If Yes, when will your pre-exist period end?_____ |

## Section 6: Where do you go for medical care?

| | |
|---|---|
| Provider name | Clinic name |
| Provider phone number | Provider address |

## Section 7: NEW APPLICANTS ONLY: COMPLETE THIS SECTION
## RENEWING APPLICANTS: GO TO THE NEXT PAGE

If this is the first time you have ever applied to the Early Intervention Program (EIP), you must document that you have HIV. Your health care provider OR case manager can sign this documentation. Get this documentation signed before you send this application to EIP.

### Applicant Authorization

I authorize my health care provider or case manager to inform the Washington State Department of Health about my HIV status. I understand this documentation is required to apply for EIP.

X_____ _____
Signature of applicant Date

_____
Print name

### Documentation

The applicant named above is applying for assistance from the Washington State Department of Health Early Intervention Program. Please provide the following information.

I HAVE EVIDENCE THAT THIS APPLICANT IS HIV POSITIVE.

X_____ _____
Signature of Health Care Provider or Case Manager Date

_____ _____
Health Care Provider or Case Manager Name and Address Phone number

For information, call the Early Intervention Program at 1-877-376-9316 or 360-236-3426.

## Section 8: Agreement and Signature

I understand that:

- I must respond to requests for information or action within deadlines or EIP may deny or stop my eligibility.
- EIP may verify any information in this application.
- I must report any change in my address, resources, income, or health care coverage. If EIP receives returned mail and cannot contact me, they may stop my eligibility.
- I may have to pay a fee to receive EIP services.
- Funding for EIP is limited and services may be changed or eliminated as necessary.
- EIP may require me to use or apply for other services before I receive EIP services.
- EIP may limit services to those that are the most cost-effective for EIP based on my other coverage options.
- EIP has grievance procedures that are available upon request. Making a grievance will not affect my EIP eligibility.

### Applicant Must Sign This Section

I give my permission for the Early Intervention Program and my health care providers, including my case manager and the Department of Social and Health Services, to share information about my medical care and insurance coverage. I give this permission for one year and 60 days from the date I sign this authorization.

I have read and understand the information in this application. The information on this form is true and complete to the best of my knowledge. I understand that if I give false or inaccurate information or fail to notify EIP of changes in a timely manner, I may lose benefits and/or EIP may require that I pay them back.

**X**_____ _____

**Signature of applicant** **Date**

**Optional**

We want to make sure all our clients receive high quality services. One way we do this is to link your information with hospital, infectious disease case reports, and special research datasets. You can receive services even if you choose not to sign this statement.

I give my permission to link identifying information from my records to other public health records in the Department of Health's Office of Infectious Disease and Reproductive Health to evaluate the way services are provided, the benefits the program provides, and the program's impact on the health of the community.

**X**_____ _____

**Signature of applicant** **Date**

# Is your application complete?

If your application is not complete, we cannot determine your eligibility. Did you:

- ☐ Answer all the questions?
- ☐ Include proof of residency?
- ☐ Include proof of income **OR** sign the "no income" statement?
- ☐ Include a copy of your Medicare card? (If applicable)
- ☐ Include a copy of insurance credibility statement or copy of your PDP or MA-PD card? (If applicable)
- ☐ Include a copy of your insurance card? (If applicable)
- ☐ Get a signature on the HIV medical documentation? (new applicants only)
- ☐ Sign the application?

If you have questions or would like to receive this application in an alternative format, call us at **1-877-376-9316.** You may also reach us through the state TDD Relay Service at 1-800-833-6388.

**Send all application materials to:**
**Early Intervention Program**
**PO Box 47841**
**Olympia, WA 98504-7841**

If you want to send your application through an overnight service, call us to get our physical address. 12/2005